SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**September 26, 2001**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Robert Meeks; Sen. Steve Johnson; Sen. Rose Antich; Sen. Vi Simpson; Sen. Samuel Smith; Rep. Charlie Brown; Rep. William Crawford; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. David Frizzell.**

Members Absent: **None.**

Senator Miller, Chairperson, called the third meeting of the Select Joint Commission on Medicaid Oversight to order at 10:10 a.m.

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

EDS Update

Mary Simpson, EDS

Ms. Mary Simpson provided the Commission with a summary and analysis of the Medicaid claims processed by EDS for the first quarter of state fiscal year (SFY) 2002. (See Exhibit 1.) In response to a question concerning whether there has been in increase in the number of claims, Ms. Simpson stated that there continues to be an increase in the number of claims which may be a result of an increase in the number of people eligible to receive Medicaid.

Targeted Physician Fee Increase

Dr. James Laughlin, pediatrician, Southern Indiana Pediatrics

Dr. James Laughlin stated that about 30% of his patients are on Medicaid. Dr. Laughlin estimates that the average office visit cost per patient is approximately $42, including overhead but not including a physician's salary. (See Exhibit 2.) The average Medicaid reimbursement per patient is $26, resulting in a loss of approximately $16 per Medicaid patient per visit.

Dr. Laughlin stated that the low Medicaid reimbursement rate for physicians will result in a decrease in the quality of care received by a patient and an elimination of a two-tier medical treatment system (i.e. patients will go straight to the emergency room instead of going to a physician's office).

In response to a question concerning how to remedy over-utilization, Dr. Laughlin stated that a financial obligation should be tied to the patient in order to create an incentive for the patient not to over-use services. The Commission asked Dr. Laughlin to provide the Commission with a list of recommendations to solve the problem.

Ms. Laura Hahn, Indiana Academy of Family Physicians

Ms. Laura Hahn reminded the Commission that SECTION 153 of the budget passed last session gave the Office of Medicaid Policy and Planning (OMPP) the authority to implement a targeted physician fee increase from 4%-6%. (See Exhibit 3). Despite the budgetary constraints the state is now facing, Ms. Hahn stated that she has a duty to help formulate a plan to increase physician fees. Ms. Hahn proposed that the state implement an increase in physician fees targeting preventive care services rather than implementing an increase for specific doctor specialties. Ms. Hahn provided the Commission with a list of preventative care codes that should be considered for such an increase. (See Exhibit 3.)

National Pharmaceutical Council presentation

Mary Kay Owens, President, Southeastern Consultants, Inc.

Ms. Mary Kay Owens gave a Power Point presentation to the Commission concerning Medicaid cost and quality initiatives. (See Exhibit 4. Exhibit 4 also contains other material that Ms. Owens distributed to the Commission). Ms. Owens informed the Commission that the two Medicaid eligible groups that are showing a significant increase in spending are: (1) the elderly; and (2) the blind and disabled. The largest group of drug consumers by dollars are the elderly, disabled, long term care patients, and medically needy patients who constitute 87% of Indiana's pharmacy expenditures. Ms. Owens stated that the primary

growth drivers for drug expenditures are volume based.

Ms. Owens stated that traditional managed care or private sector plans for cost containment may not be applicable to the Medicaid population because of the different make up of the group. For example, Ms. Owens stated that prior authorization requires expensive administrative costs and still results in high approval rates. Limiting the number of prescription benefits may also not be feasible for Medicaid patients since many Medicaid patients are elderly and use multiple drugs. Requiring generically available drugs may also be difficult for the Medicaid population since many Medicaid patients are using newer drugs that do not yet have a generic equivalent. Formularies do not ensure the appropriate use of the product.

Ms. Owens informed the Commission that a couple of states are successfully utilizing disease management programs in an attempt to reduce unnecessary expenditures and improve disease control. Ms. Owens warned the Commission that a disease management program would require initial administrative funding and may take several years before the full costs and benefits are realized.

In response to a question concerning the prevention of fraud and abuse in the Medicaid program, Ms. Owens stated that computer software exists that can help detect suspicious behavior. Responding to a question concerning limiting the amount of a prescription that can be filled, Ms. Owens stated that the state would have to allow for some overlap so that a person would not run out of a prescription before the person could get the prescription refilled.

Prior Authorization

Dr. John Nurnberger, Director, Institute for Psychiatric Research, IU Department of Psychiatry (on behalf of the Mental Health Association of Indiana)

Dr. John Nurnberger stated that prior authorization would adversely affect people with severe psychiatric disorders. New medication is resulting in fewer side effects and is safer and easier for a patient to take. Patients are more likely to continue using these new medications and stay out of hospitals. Dr. Nurnberger stated that the state should be encouraging the use of these new medications; however, prior authorization would result in the decreased use of these new drugs.

Charlie Hiltunen

Mr. Charlie Hiltunen stated that other cost-saving options such as computer software that helps detect fraud should be considered before considering prior authorization. The Drug Utilization Review (DUR) Board should also be looked to for direction in helping the state with the state's over-utilization problem. In response to a question concerning whether the DUR Board has the authority and staff needed for utilization review, Mr. Hiltunen stated that the DUR Board does have the statutory authority and the expertise required for utilization review.

Disease Management

Rita Mills, President, CEO, Managed Health Services
Dr. Michael Lynch, Medical Director, Managed Health Services

Ms. Rita Mills and Dr. Michael Lynch from Managed Health Services (MHS) gave a Power

Point presentation, making the following points:

- MHS made a decision not to enter the commercial market and concentrates solely on Medicaid.
- Medicaid's continued price pressures are driven by technology, an aging population that demands more services, and a rising prevalence of chronic diseases such as asthma, diabetes, and HIV.
- Healthcare should focus on preventive services to keep the "well" well.
- Disease management should take place and include a system to coordinate and improve all of the services provided to a patient. Components of disease management include: health risk assessment, prevention counseling and services, patient and caregiver education, case management, primary care, specialty care, outpatient diagnosis and treatment, inpatient care, rehabilitation/long term care, and home health.
- MHS has developed partnerships with several pharmaceutical companies to provide its members with educational materials when enrolled in various disease management programs. MHS has disease management programs for: diabetes, asthma, prenatal care, sickle cell anemia, smoking cessation, and obesity.

(See Exhibit 5, Power Point presentation).

Medicaid Hospital Reimbursement

Phil Skinner, Central Indiana Patient Account Management (CIPAM)

Mr. Phil Skinner stated that there is a discrepancy in the regulations concerning billing guidelines for outpatient services and inpatient services provided on the same day. Mr. Skinner stated that he believes the regulations use the term "add-on" when it should use the term "stand alone". (See Exhibit 6). Mr. Skinner directed the Commission's attention to a statement further on in the regulations that supports this theory since it states that add on services are not appropriate. Mr. Skinner informed the Commission that he has been reimbursed properly by EDS but that a written explanation should be published to clarify this situation for other providers.

Tina Trosper, CIPAM

Ms. Tina Trosper stated that there needs to be a more collaborative effort between the provider and the administration to simplify Medicaid billing. Ms. Trosper provided the Commission with a list of four possible ways that Medicaid billing can be simplified. (See Exhibit 7.) One example that Ms. Trosper gave the Commission concerned the forms filed with EDS for spenddown. The process for obtaining and billing claims that involve a spenddown is very time consuming and problematic. Ms. Trosper stated that billing for a spenddown can be accomplished more efficiently through EDS' system without the need to complete an additional form by treating a spenddown in the same manner as a deductible is treated in the private insurance sector.

Long Term Care Reimbursement

Evelyn Murphy, Long Term Care Director, Office of Medicaid Policy and Planning (OMPP)

Ms. Evelyn Murphy informed the Commission that the regulations affecting long term care reimbursement will go into effect on October 1, 2001. The regulations address the following issues: case mix methodology, Medicare crossover claims, and facilities with less than a 90% occupancy rate. In response to a question, Ms. Murphy stated that these

regulations were adopted by emergency rule.

Steve Albrecht, Economic Affairs Director, Indiana Health Care Association (IHCA)

Mr. Steve Albrecht told the Commission that IHCA has been meeting with OMPP to discuss the proposed regulations affecting long term care reimbursement. Mr. Albrecht informed the Commission that Indiana is one of the top ten states with a shortfall in funding for nursing home care (See Exhibit 8) and stated that Indiana is going in the wrong direction with the cuts that will go into effect October 1, 2001.

Jim Leich, Indiana Association of Homes and Services for the Aging (IAHSA)

Mr. Jim Leich stated that the cuts for long term care that will be going into effect will affect individuals differently, but will directly impair the quality of care provided to the patients. Mr. Leich stated that he is encouraged that OMPP has offered a couple of proposals that will close some loopholes that exist and hopes that OMPP will continue to pursue these proposals. The Commission asked Mr. Leich to provide the Commission with a summary of possible solutions of other revenue sources that OMPP can pursue, keeping in mind Indiana's tight budget constraints.

OMPP Update

Melanie Bella, Director, OMPP

Ms. Melanie Bella introduced herself to the Commission as the new Director of OMPP. She addressed the following issues:

- Physician fee increase: Ms. Bella stated that OMPP is not currently in a position to implement an increase in physician fees.
- Pharmacy Benefit Manager (PBM): OMPP is predicting that a PBM will begin in August, 2002. EDS is currently performing some of a PBM's functions for OMPP. OMPP has been working with a consultant to appropriately define the request for proposal (RFP). Bids for a PBM will probably begin in January, 2002.
- Prior authorization: OMPP has released proposed rules for prior authorization for five drug categories, none of which include psychotropic drugs. OMPP has set a target date of January 1, 2002, for these proposed rules to take effect. Ms. Bella stated that the proposed language had been tightly defined so as to exclude mental illness drugs. These rules will hopefully go before the FSSA board in November, 2001.
- Hospital reimbursement: OMPP will be looking at suggestions to cut costs.
- Long term care reimbursement: SB 309- 2001 (intergovernmental transfers)- OMPP has submitted a plan for the $10 million and will be negotiating what percentage the state will retain.
- Disease management: OMPP has compiled preliminary data concerning the state's expenditures for four disease states: diabetes, asthma, congestive heart failure, and AIDS. (See Exhibit 9.)
- 1115 Demonstration Project Opportunities: OMPP distributed a proposal of four possible options to increase federal funding. (See Exhibit 10.) Ms. Bella stated that the most viable option is the Ticket to Work and Work Incentives Improvement Act (TWWIIA).
- Leveraging: Ms. Bella stated that the most viable leveraging opportunities exist in the school-based health services and the county welfare programs.

The meeting was adjourned at 1:25 p.m.